HCP

Maine Revenue Services
Health Care Provider Tax
Reconciliation Return

031450000

Registration No.	Period	Due Date

1. Entity Information

ADDRESS CHANGE?: If your address above is incorrect, please make the appropriate changes to the preprinted address.

Use this area only to report changes in your business

2. ***OUT OF BUSINESS? Check here*** ☐, return permit to Bureau and complete information at right. Date closed _____

3. ***OWNERSHIP CHANGE?*** If you have changed ownership, indicate the date when this occurred here _____ and check off type of change below:

☐ Incorporated ☐ Partner added or dropped
☐ Other (explain on reverse)
☐ Sold to _____

4. ***NAME CHANGE?*** Attach explanation to this return.

1. Annual revenue for fiscal year identified above 1. ☐☐,☐☐☐,☐☐☐.☐☐

2. Health Care Provider Tax (Line 1 multiplied by 6%) 2. ☐☐,☐☐☐,☐☐☐.☐☐

3. Less: Monthly estimated payments made 3. ☐☐,☐☐☐,☐☐☐.☐☐

4. Additional Amount Due (Line 2 less line 3. Use Line 5 if this is a credit amount 4. ☐☐,☐☐☐,☐☐☐.☐☐

5. Credit due If Line 2 minus line 3 is a credit amount, enter the amount to the right.

If you wish a refund rather than a carry forward to the next period, check here ☐ 5. ☐☐,☐☐☐,☐☐☐.☐☐

Instructions:

Line 1. For nursing homes, enter your annual net operating revenue for the fiscal year identified above. For residential treatment facilities, enter your annual gross patient services revenue for the fiscal year identified above.

Line 3. Enter the total of all estimated payments made during the fiscal year period identified above.

Mail To:
Maine Revenue Service
P.O. Box 1064
Augusta, ME 04332-1064

Signature	Title	Date	Phone #	☐☐